STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY GEORGE DEUKMEJIAN, Governor

**DEPARTMENT OF HEALTH SERVICES**
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320

April 23, 1990

TO: All County Welfare Directors
All County Administrative Officers

Letter No: 90-39

SUBJECT: MEDI-CAL CARD ISSUANCE - SSI/SSP RECIPIENTS

Enclosed is a copy of a form used by the Social Security Administration (SSA) authorizing the county to issue Medi-Cal cards to Supplemental Security Income/State Supplemental Payment (SSI/SSP) program recipients. Some counties have expressed concern about recognizing this as an official form because it lacks SSA-identifying information (i.e., an official seal, letterhead, or form number).

Department of Health Services staff contacted the SSA and were assured that this form is an official SSA document. It is most likely used only by the Los Angeles Teleservice Center (TSC) because of the high volume of SSI cases handled by that office.

Therefore, this is to advise you that counties may use this form as SSA verification of entitlement to SSI benefits and issue SSI-based Medi-Cal cards to the client. Counties are reminded to follow the instructions in Medi-Cal Eligibility Manual Procedures Section 14B, 2e (Handling Erroneous Nonreceipt of [SSI/SSP] Medi-Cal Cards) when issuing the cards.

If you have questions regarding the information in this letter, please contact Maggie Roggero of my staff at (916) 324-4966.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaison
Medi-Cal Program
Consultants

Expiration Date: April 23, 1991

# MEDI - CAL REFERRAL

TO: MEDI-CAL OFFICE , [redacted] COUNTY

FROM: SOCIAL SECURITY ADMINISTRATION

SSA Office Address/Phone: Los Angeles TSC, PO Box 76988, Los Angeles 90076, (800) 234-5772

Name of Issuing Representative [redacted] Pos # [redacted]

The recipient named below has not received Medi-Cal cards for the months of _____.

According to SSA records, the recipient was eligible for SSI/SSP payments for these months.

## RECIPIENT IDENTIFICATION

Name [redacted]

SSN [redacted]

Date of Birth [redacted]

Address [redacted]

Phone [redacted]

If unable to act on own behalf:

Contact's Name _____

Contact's Phone _____

## REFERRAL INFORMATION

SSI Category: Aged Blind (Disabled)

Prepaid Health Plan: Yes (No)

Other Health Insurance: Yes (No)

Medicare: Yes (No)

Claim # _____

SSI Payment Status Code A A

If COA, Date of Input —

If Deceased, Date of Death —

## REASON FOR REFERRAL

1 - New Eligible

(2 - Lost Card)

3 - Labels Used Up

4 - Not Received

5 - Error/Mutilated

6 - Needs MEDI Labels

## SSA DATE STAMP

LOS ANGELES, CALIF

NOV 29 1989

91702

SSA TELESERVICE CENTER

Memo to file